

## ADDS ATR ORIENTATION INFORMATION

I, \_\_\_\_\_ have received a written explanation and have discussed with an ADDS ATR counselor the details regarding:

1. General nature and goals of the ADDS ATR program.
2. Client records, including a summary of the Federal Law and regulations regarding confidentiality of records.
3. Client responsibilities, agreements and rules governing conduct and infractions that can lead to disciplinary action or discharge from the ATR program.
4. List of locally available ATR covered services and providers approved by the Iowa Department of Public Health (IDPH).
5. Client choices for ATR covered services and providers
6. I realize that I will be responsible for keeping in contact (in person and/or by phone) and not letting thirty days lapse or else I will be discharged.
7. I will notify staff of changes in my phone number, address or collateral contacts.
8. I realize that I will be responsible for bringing in all receipts by my next appointment. If this is not followed I will not be able to use my supplemental needs and may possibly be discharged.

I understand that the Auditor of the State of Iowa or any authorized representative of the State of Iowa and, wherever federal funds are involved, the Comptroller General of the United States or any other authorized representative of the United States Government, shall have access to, and the right to examine my ATR client record.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor: \_\_\_\_\_ Date: \_\_\_\_\_